State of California—Health and Human Services Agency
California Department of Public Health

MICHAEL WILKENING
Acting Director

EDMUND G. BROWN JR.
Governor

PUBLIC COMMENT REQUESTED

March 5, 2015

The California Department of Public Health, Office of Health Equity (CDPH-OHE) is requesting public comment on the California Reducing Disparities Project (CRDP) Phase 2 Draft Pre-Solicitations for Capacity Building Pilot Projects Today's release is for the purpose of gathering public comment only. The public comments that we receive will be used to help finalize the solicitation document. CDPH is concurrently releasing Draft Pre-Solicitations for the CRDP Phase 2 Statewide Evaluation Team, Technical Assistance Providers and Implementation Pilot Projects. These documents can be found at: http://www.cdph.ca.gov/programs/Pages/OHECaliforniaReducingDisparitiesProjectPhaseII.aspx

In order to ensure high quality solicitations that meet program objectives and community needs, the Office of Health Equity is asking interested stakeholders, subject matter experts and community members to review the Draft Pre-Solicitations and provide feedback on how to improve the documents. We invite feedback on all sections of the Draft Pre-Solicitations, but are particularly interested in receiving feedback on the following areas:

- Program evaluation guidelines and evaluation plan components
- Minimum and desired qualifications for Proposers or Applicants
- Scoring criteria

In reviewing Draft Pre-Solicitations, commenters are encouraged to consider the following overarching questions: What elements work? What elements could be improved? Are any important elements missing? Are instructions for Proposers or Applicants clear? Please comment on each draft separately so that comments can be submitted to the appropriate email address. Make comments specific referencing the line number and explaining why a change is warranted and how the change would improve the pre-solicitation.

All comments for the Capacity Building Pilot Projects must be submitted in writing by March 25, 2015 to CRDPpilot@cdph.ca.gov

CDPH is not soliciting any applications or proposals at this time. The draft pre-solicitations are being released for public comment only. CDPH will review all submitted comments and revise

the draft pre-solicitations as appropriate. Final solicitations will be released upon completion of the revision process.

Thank you for your interest and help to improve the California Reducing Disparities Project.

Draft Pre-Call for Applications

Native American Capacity Building Pilot Projects

DRAFT: CRDP-25

State of California

California Department of Public Health

Office of Health Equity

March 5, 2015

Table of Contents

I. Introduction

A. Overview

The purpose of this Call for Applications is to award Capacity Building Pilot Projects (CBPP) grants to organizations that provide promising mental health interventions to the California Native American population and are in need of capacity building services to successfully participate as a California Reducing Disparities Project (CRDP) Implementation Pilot Project (IPP). There are five separate Calls for Application, one for each of the five CRDP Phase 2 target populations (African American; Asian Pacific Islander; Latino; Lesbian, Gay, Bisexual, Transgender and Queer/Questioning; and Native American). Applicants for this grant program must currently be providing services to prevent mental health from becoming severe and disabling within the California Native American population through an existing Community-Defined Evidence Practice (CDEP). CDEPs must be acknowledged by the community as effectively meeting its unique mental health needs in a culturally and linguistically competent manner.

We anticipate 35 IPP grants will be provided through five population-specific applications, with seven grants awarded to applicants serving the Native American population. Approximately 20 will start as IPPs and 15 will start as CBPPs. CBPP grants are limited to organizations with operating budgets under $500,000 that have significant need for organizational capacity building. The grant funding period is six months. Those CBPPs that successfully complete all established requirements will be able to participate as IPPs.

In order to support their ability to complete the IPP requirements, CBPP grantees will receive extensive support from the CRDP Statewide Evaluation Team and the Native American Population Technical Assistance Provider. The Statewide Evaluation Team will provide each CBPP with technical assistance to develop a plan and infrastructure to evaluate the effectiveness of its program utilizing culturally and linguistically competent approaches. The Native American Technical Assistance Provider will support each Native American CBPP to meet the organizational requirements for IPP eligibility.

IPP grants were created to fulfill the strategy derived from the CRDP Phase 1 Strategic Plan, which is available in the Bidder's Library. The Strategic Plan was created through an open, community process, guided by five Strategic Planning Workgroups (SPWs). Each SPW is comprised of a broad representation of the diversity within their respective population group including, but not limited to, community leaders, mental health providers, consumer and family members, individuals with lived experience and academia. The five SPWs worked to identify new service delivery approaches defined by multicultural communities for multicultural communities using community-defined evidence to improve outcomes and reduce disparities. Native American IPP Grants are intended to fund, build capacity to support and evaluate CDEPs that are implementing

strategies identified by the Native American SPWs in the Population Report, which is available in the Bidder's Library.

Applicants for both the Native American IPP and CBPP grants must provide a CDEP to California's Native American community. If an organization provides services to individuals outside the Native American population, it may continue to do so, but IPP funding and evaluation efforts are limited to the Native American population.

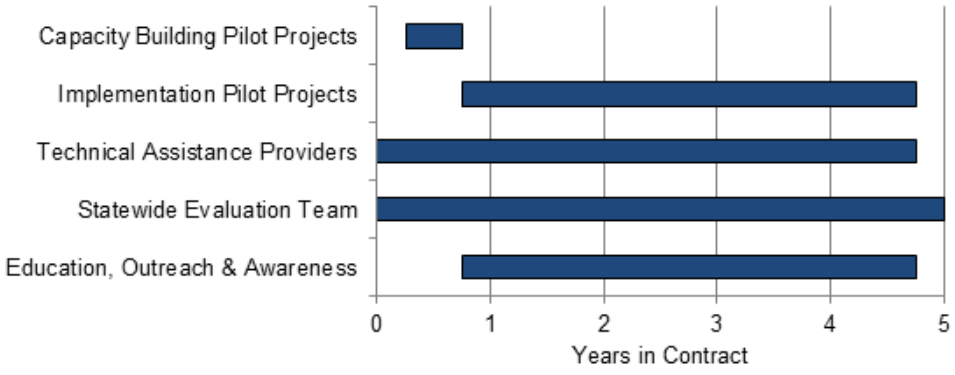
CRDP funding is intended to supplement, not replace a program's current funding. IPP funding may not be used to duplicate or supplant existing funding.

The IPPs are one component of CRDP Phase 2, which includes:

- Pilot Projects – Pilot Projects (including CBPPs and IPPs) are the central component of CRDP Phase 2. Pilot Projects are existing CDEPs that provide culturally competent mental illness prevention and early intervention services to members of a CRDP target population but have not yet been effectively validated.
- Education, Outreach and Awareness Consultants – Statewide and local consultants will be engaged to bring together community stakeholders and resources to address mental health disparities.
- Technical Assistance – Population-specific Technical Assistance (TA) Providers will be contracted to work with Pilot Projects to develop their administrative and programmatic capacity.
- Evaluation – Evaluations will be performed by a Statewide Evaluation Team and by evaluators at each Pilot Project to demonstrate the overall effectiveness of CRDP Phase 2 and the effectiveness of each of the Pilot Projects.

In order to align the contractors and grantees across Phase 2 components, it is anticipated that the project start date for IPPs will be approximately six months after grant awards are announced while CBPPs will start immediately. The figure below displays the anticipated sequencing of CRDP Phase 2 components.

Figure 1. Sequencing of Phase 2 Components



For more information about CRDP Phase 2, see Attachment 13, CRDP Phase 2 Background.

B. CDEPs

For the purposes of this grant program, a CDEP is a set of bottom-up practices derived from a community's ideas of illness and healing or positive attributes of culture or from traditional practices. In addition, the practice has been used by the targeted community, which has determined it to yield positive results through community consensus. While some CDEPs may have been measured empirically, this is not necessary to show that there is a consensus in the community regarding its effectiveness. CDEPs can include a range of culturally tailored treatment approaches or support (Martinez, 2010; CIBHS, 2014; Community Defined Evidence Project Work Group, 2007). These services are often culture-specific practices that are supported by community experience but not yet recognized or funded by the public mental health system.

The goal of CRDP is to invest in selected CDEPs as IPPs in order to evaluate and validate those practices as effective in preventing mental illness from becoming severe and disabling. To be eligible for IPP funding, the CDEP must not have already been recognized as an evidence-based practice. Previous evaluation of the CDEP will not disqualify a program from consideration, nor will the absence of previous evaluation. The CDEP must be able to be evaluated, however. Funding, supporting and evaluating CDEPs lies at the heart of CRDP.

As MHSA-funded programs, IPPs must focus on achieving improved mental health outcomes for individuals at increased risk of mental illness or individuals with recent onset of mental illness. IPPs and their CDEP may provide services to families and other community members provided that the services lead to improved mental health outcomes for targeted individuals. Programs that address substance use are only eligible for funding in the context of co-occurring mental health disorders or as a risk factor for mental illness and for the purpose of evaluating the program. Funding must not supplant existing funding for the services.

C. Technical Assistance

In order to support CBPPs ability to advance to IPP stage, the CRDP will provide technical assistance through two contractors.

The Statewide Evaluation Team will establish guidelines for and support each CBPP in the development of an evaluation plan. They will provide a framework and basic standards and provide support to empower CBPPs to build upon the framework to develop evidence of program effectiveness in a manner that is culturally and linguistically competent and is suitable for their community and programmatic approach. Throughout the entire process (Including evaluation plan development and refinement,

data collection and evaluation implementation) the Statewide Evaluation Team will provide support as needed and feedback at established intervals.

The Native American Technical Assistance (TA) Provider will support each Native American IPP to improve the sustainability of the organization, focusing on completing the IPP application and fulfilling IPP requirements. It is understood that individual needs will vary from one project to the next.

D. GOALS

The overarching goal of the CBPP stage is to prepare grantees to advance to the IPP stage. CBPPs that successfully complete all of the requirements of Goals 1 and 2 during the CBPP funding period will be eligible for advancement. CDPH will have the sole authority to determine if a CBPP has met all requirements.

Goal 1: Develop the Capacity to Evaluate the CDEP's Effectiveness

CDEP evaluation is the cornerstone of CRDP Phase 2. Rather than imposing a top-down, one-size-fits-all approach, pilot projects will be empowered to develop their own approach, within the guidelines developed by the Statewide Evaluation Team. Under this empowerment model, it is critical that each CBPP develop the capacity to plan and implement its own evaluation. CBPP Grantees will work under the guidance of the Statewide Evaluator to develop a Proposed Evaluation Plan, which will include:

1. Evaluation Approach: This describes specific details in regards to how the Grantee would implement a program evaluation that is both culturally and linguistically competent and addresses the needs of the community that it is serving. The approach must describe in detail the plan for gathering qualitative and quantitative data and must detail how community stakeholders would be engaged throughout the evaluation process.
2. Theory of Change and Logic Model: The Theory of Change is a detailed description of the step-by-step process that theoretically will lead to the end goal, including a clear articulation of the assumptions made to explain the change process. The Logic Model is a planning tool that provides detailed description of how the program is expected to improve mental health outcomes of program participants. Samples of the Theory of Change and Logic Model are provided in the Bidder's Library.
3. Key Questions and Outcome Measures: This should include the specific, detailed questions the evaluation will seek to answer and what outcomes will be tracked. This must include mental health outcomes for individuals at increased risk of mental illness or with recent onset of mental illness.
4. Timeline: This should include planned due dates for included requirements and milestones that show tangible process towards meeting each requirement.
5. Evaluation Staffing Model: If the Grantee proposes to utilize an in-house staff evaluator, the Grantee shall provide a description of the key qualifications and

essential duties of the principal evaluator. In the event that the Grantee proposes to utilize a contractor to meet its evaluation requirements, the Grantee must provide the contractor's:

   i. Statement of qualifications, which demonstrates the Contractor's to develop and implement an evaluation plan, working in a culturally and linguistically competent manner and engaging the community throughout the process
   ii. Detailed statement of work, which demonstrates the ability of the Grantee to ensure effective and timely implementation of the Evaluation Plan

6. Continuous Quality Improvement Plan: The Grantee must provide a detailed plan describing ongoing program monitoring activity that ensures program integrity and continuous quality improvement. This should include:
   i. Who within the organization will be involved?
   ii. When and how often will results be reviewed?
   iii. Who will decide how programs should be changed as a result of the evaluation?
   iv. Which stakeholders will be involved and in what setting? (Stakeholders include any persons interested in or impacted by the CDEP, including clients, family members and other community members.)
   v. How will stakeholder feedback be incorporated?
7. Update Plan: The Grantee shall update the Evaluation Plan annually, review with the Statewide Evaluation Team and obtain approval for any deviations from CDPH. The applicant must provide a detailed plan indicating how the Evaluation Plan will be updated and reviewed to meet this requirement at least once every contract year.
8. Institutional Review Board (IRB) Review (If necessary): IPPs may be required to obtain IRB approval if the evaluation is deemed to constitute "human subject research" (see http://www.hhs.gov/ohrp/humansubjects/commonrule/ for more information). If the Grantee has determined that it will need IRB approval, the Proposed Evaluation Plan should reflect this requirement. The Statewide Evaluation Team will independently make a recommendation to CDPH as to which IPPs must pursue IRB approval.
9. Evidence-Based Practice (Optional): The Applicant may wish to pursue review and acceptance as an Evidence-Based Practice, at its option. Doing so would require experimental or quasi-experimental evaluation design. The Grantee should review requirements from Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices (http://www.nrepp.samhsa.gov/). If the Applicant plans to pursue review and acceptance, it must provide a detailed description of how it would meet the requirements.

Goal 2: Improve Sustainability of the Organization

The purpose of the Capacity Building grant program is to allow select, smaller organizations with less capacity that are providing a CDEP the opportunity to participate in CRDP Phase 2. These organizations may lack adequate organizational

infrastructure to sustainably and stably provide their CDEP at a scale sufficient to allow for validation as an effective practice.

In order to achieve this goal, CBPPs will work closely with the Native American Technical Assistance (TA) Provider. The TA Provider will provide each CBPP with tailored assistance to complete the requirements to advance to the IPP phase. The CBPPs shall participate in technical assistance activities, including an initial assessment, trainings and one-on-one coaching as necessary.

Requirements:

A. Capacity Building Plan

Within the first 30 days of the grant period, the Native American TA Provider will provide a written assessment of each Native American CBPP's organizational strengths and limitations regarding its ability to become eligible for the IPP stage. We expect the written assessment to be developed through a collaborative process, in which the Native American TA Provider and the CBPP will work to identify any necessary steps to fulfill the requirements to advance to IPP status. Each CBPP will be required to develop a Capacity Building Plan that includes milestones and their anticipated completion dates leading to fulfilling the IPP requirements, which at a minimum shall include developing an:

- Workplan, which details the major tasks and activities of IPP implementation, including an associated schedule, due dates and resource requirements for each task and activity;
- IPP Budget, which corresponds with the Workplan details and justifies how IPP grant funds will be spent; and
- Organizational Staffing Model, which details the specific individuals who will be responsible for guiding IPP implementation and completing the tasks and activities and the requirements and qualifications for each position.

B. Midpoint Reports

By the end of the third month of the grant period, the CBPP shall provide a 2-page (minimum) report, detailing the organizational development activities conducted during the quarter. The reports shall focus on the timeliness and progress in implementing the Capacity Building Plan, including participation in support activities provided by the TA Provider and actions taken as a result of these activities.

E. IPP GRANTS

To enter the IPP program, a CBPP must provide a detailed workplan, budget, staffing model, theory of change, logic model and evaluation plan. The CBPPs are solely responsible for meeting requirements of the CBPP grants and for progressing to IPP

status. Those CBPPs that successfully complete all established requirements within the established timeframe will be awarded an IPP. However, CDPH does not make any assurances or guarantees that CBPPs will successfully complete all requirements to obtain an IPP grant.

CBPP applicants should review the IPP Call for Applications, as they will be expected to complete the IPP Application in order to advance to the IPP stage. If accepted as IPPs, they will be required to fulfill all IPP Goals in order to continue receive IPP grant funding. IPP Goals are provided in Attachment 11.

The IPP grant funding period will be four years. Grants will be for a maximum of $285 thousand per year. A minimum of 20% of grant funds must be spent on Pilot Project evaluation.

F. ADMINISTRATIVE SECTION

1. Key Action Dates

Key activities and times for this Call for Applications are presented below. This is a tentative schedule. Any updates to this schedule will appear as an addendum to this Call for Applications.

ACTIVITY	ACTION DATE
Call for Applications release date	X
Bidder's Conference	X + 7
Written question submittal deadline	X + 14
Optional Letter of Intent deadline	X + 14
Questions and Answers posted	X + 21
Final date for application submission	X + 56
Notice of intent to award	X + 140
Proposed award date	X + 147
Project start date	Y
Project end date	Y + 6 months

2. Contact Information

Contact
Phone
Address

3. Applicant's Responsibilities for Submitting an Application:

Applicants must take the responsibility to:

- Carefully read this entire Call for Applications;

- Ask the appropriate questions in a timely manner;
- Submit all required responses in a complete manner by the required date and time;
- Make sure that all procedures and requirements of the Call for Applications are followed and appropriately addressed; and
- Carefully reread the entire Call for Applications before submitting an application.

4. Optional Letter of Intent

Potential applicants are encourage to send a letter of intent to CDPH, using the contact information provided in I.E.2. Letters should be postmarked by and should include:

- Name and number of Call for Application
- Population targeted
- Budget request (approximate)
- Short description of project

Letters of intent are not binding. Those submitting a letter may elect not to submit an application.

II. Eligibility

A. Minimum Qualifications

An organization applying to become a CBPP must possess the following qualifications:

1. Applicant is the direct provider of a CDEP that prevents mental illness from becoming severe and disabling among California's Native American population. The CDEP must have been provided by the applicant for a minimum of two years.
2. Applicant is a 501(c)3 non-profit with an office in California, a public college or university or a local government agency in California (including Tribal government).
3. Applicant's annual operating expense budget has not exceeded $500,000 on average during the past two years.

B. Desired Qualifications

Scoring of Applicant qualifications will be based on the following criteria:

1. Applicant is uniquely qualified to provide mental health services to California's Native American population, which includes:
   a. Significant experience working to prevent mental illness, through but not limited to:
      – Practices That Build Capacity and Consciousness in Local Communities;
      – Practices That Increase Service Accessibility;
      – Practices That Raise Awareness About Mental Health;
      – Innovative Engagement Practices;
      – Community Outreach Practices;
      – Organizational Infrastructure Practices;
      – Interventions and Treatments; and/or
      – Locally Adapted Evidence-Based Practices.

   b. Demonstrated ability to work in a culturally and linguistically appropriate manner with the California Native American population

   c. Strong support from the community that the applicant serves. Examples of support could include but is not limited to: financial; volunteer by client/consumer/family members; and general. Support shall be demonstrated through letters of support

   d. Strong community engagement, including specific roles for clients/consumers/family members in support of the applicant organization and/or the design and/or provision of the CDEP

e. Demonstrated collaboration with the mental or behavioral health department/agency in the applicant's county in a meaningful manner to provide the CDEP service. This would include operational partnerships in the provision of CDEP services, beyond financial support. If the applicant is a County, it should demonstrate its collaboration with local CDEPs in their provision of services, beyond financial support.

2. Applicant would benefit from Technical Assistance.
3. Applicant's CDEP has the potential to significantly impact mental health in California's Native American population and has the potential to be effectively evaluated, which includes:
   a. Addresses a community need as identified as a finding or a recommendation in the draft CRDP Strategic Plan
   b. Evidence exists to suggest program effectiveness. This could include findings from limited or informal evaluations that have been conducted, case studies and/or surveys or testimonies from program participants, family members, community members and/or other stakeholders
   c. Has the potential for producing evidence of successful mental health outcomes among individuals at increased risk of mental illness or with recent onset of mental illness.

In addition to the desired qualifications, consideration will be given to ensure geographic level diversity is achieved.

III. Narrative

Provide a description of your program, your management plan and how you intend to fulfill the goals of the CRDP Phase 2 Native American CBPP grant. The narratives, in total, should be no more than ten pages, not including Appendices, and must be typed or printed using a standard Times New Roman, Arial or Calibri 12-point font, single-spaced with a blank line between paragraphs and minimum 1-inch margins on 8-1/2" x 11" paper.

If narrative exceeds the 10-page limit, only the first ten pages will be reviewed and scored.

Please review Section V. Administration carefully, which describes the required format for the application and the process for submitting it.

The Narrative will be scored up to 200 points. All items are required and **MUST** be responded to individually. Please provide clear, concise, detailed responses to each of the following:

1. Program (80 Points)

In this section, describe how your program prevents and/or reduces the severity of mental illness in California's Native American population in a culturally and linguistically competent manner. Please include the following information:

a. What community mental health need or opportunity does this program address? Which specific need or recommendation from the CRDP Native American Population or Statewide Strategic Plan is addressed by your program?
   – What risk factors are addressed and how are they addressed?
   – What are the consequences of failing to meet these needs?
b. What outcomes do you expect will be realized as a result of the work proposed? These outcomes must include mental health outcomes for individuals at increased risk of mental illness or with recent onset of mental illness.
c. Provide a detailed overview of your proposed program:
   – What elements are included in the program? (Approaches, strategies, methods, products or practices delivered?)
   – To whom are the program elements delivered?
   – Where/in what setting are the program elements delivered?
   – When and for how long are the program elements delivered?
   – What staff are providing the elements and what are their qualifications to deliver the program in a culturally and linguistically competent manner?
d. In what ways does your program impact the community mental health need identified? Why is it effective?
e. What existing evidence suggests program effectiveness? This could include findings from limited or informal evaluations that have been conducted, case studies and/or surveys or testimonies from program participants, family members, community members and/or other stakeholders
f. How does your program demonstrate cultural and linguistic competence in the provision of its services?

2. Organization (60 Points)

In this section, describe your organization's unique qualifications to provide mental health services to the Native American community within California, including the following information:

a. An overview of your organization's history and how the program fits into the structure, including the individual(s) who will oversee implementation

activities (if available, provide an organizational chart as an attachment that does not count towards the page limit).

b. An overview of your organization's experience providing mental health services to California's Native American population in a culturally and linguistically appropriate manner. Please include details about the specific Native American populations that your organization serves and other programs and services that your organization provides to California's Native American population.
c. Evidence of strong support from the community that you serve, including but not limited to financial support, and volunteer support by client/consumer/family members, and testimonials and letters of support by members of the community.
d. Evidence of strong community engagement, including specific roles for clients/consumers/family members in support of the applicant organization and/or the design/provision of the CDEP.
e. Evidence of collaboration with the county in a meaningful manner to provide the CDEP service. This would include operational partnerships in the provision of the CDEP services, beyond financial support by the county. If the applicant is a County, it should demonstrate its collaboration with local CDEPs in their provision of services, beyond financial support.

3. Evaluation (40 Points)

In this section, describe in what ways the CDEP has the potential for producing evidence of successful outcomes, including the following information:

f. What evaluation and/or data collection currently occurs within the organization?

5 points

g. What existing staff, policies and operations currently support data collection and/or program evaluation?

5 points

h. What evaluation design strategies, measures and additional data do you propose to use to enhance the evaluation of your program in a culturally and linguistically competent manner?

30 points

4. Technical Assistance Needs (20 Points)

In this section, describe how your organization would benefit from technical assistance and training, including the following information:

a. Describe at least three areas that your organization would benefit from development or technical assistance. (10 points)
b. Please indicate which staff members would be designated to work with the Technical Assistance Provider, a summary of their background, their role in your organization and their time availabilities. (10 points)

IV. Scoring Process and Criteria

A. About this Section

This section explains how the application will be reviewed. It describes the review stages and scoring of all applications. Each application will be evaluated and scored based on its response to the information requested in this Call for Applications.

During the review and selection process, CDPH OHE may interview Applicants either by telephone or in person at CDPH for the purpose of clarification and verification of information provided in the application.

B. Application Scoring

To analyze all applications, CDPH OHE will organize a Scoring Team. The applications will be analyzed in three stages:

Stage One: Administrative and Completeness Screening (Pass/Fail)

CDPH OHE will review applications for compliance with administrative requirements and completeness. Applications that fail Stage One will be disqualified and eliminated from further review.

Stage Two: Application Review (200 points of total score)

Applications passing Stage One will be submitted to the Scoring Team to be scored based on the Scoring Criteria in this Section. Applicant(s) will be scored based on:

Part A, Minimum Qualifications. All minimum qualifications will be scored on a pass/fail basis. Only applicants who meet all minimum qualifications will proceed to Part B.

1. Applicant is the direct provider of a CDEP that prevents mental illness from becoming severe and disabling among California's Native American population. The CDEP must have been provided by the applicant for a minimum of two years.
2. Applicant is a 501(c)3 non-profit with an office in California, a public college or university or a local government agency in California (including Tribal government).
3. Applicant's annual operating expense budget has not exceeded $500,000 on average during the past two years.

Part B, Desired Qualifications. All desired qualifications will be scored on a point basis based on the Applicant's narrative. There is a maximum of 200 points available. Reviewers will develop a score as well as any areas requiring clarification in Stage Three. Scores will be based on the following overarching standards:

Maximum of Points Available	Applicant fully meets the qualification and has provided thorough documentation in support.
Midrange of Points Available (Roughly 75%)	Applicant barely meets the qualification. Applicant is barely adequate and/or support documentation is barely adequate.
Zero Points	Applicant wholly fails to meet the qualification.

1. Program (80 Points)
2. Organization (60 Points)
3. Evaluation (40 Points)
4. Technical Assistance (20 Points)

Stage Three: Interviews

A maximum of six applicants with the highest scores will advance to Stage Three. In addition, applicants must receive a score of at least 120 points in Stage Two to qualify for Stage Three.

The scoring team will develop clarifying questions for the Interview Stage. Based on the interview, the scoring team may assign up to 80 points additional points to the Stage Two score.

Stage Four: Site Visit/Verification

Following grant awards, CRDP and TA Provider staff will conduct a site visit to verify all information provided in the written application and interview. Identification of any material deviation from what is provided in the application may result in the immediate termination of CBPP grant funding, at the sole discretion of CRDP.

C. SCORING TEAM

A scoring team will be assembled that will include CDPH staff and select subject matter experts. The team will be assigned by CRDP leadership. Scoring team members shall have no financial connection to any organizations applying for Implementation Pilot Project grants.

The scoring team members will review each application thoroughly and assign a final score.

To determine the award of grant funding, applications will be ranked by total score from highest to lowest. If necessary, adjustment may be made to ensure geographic and subpopulation diversity. CDPH will provide justification for any adjustments made.

V. Administration

A. Application Format

Required Format for an Application

All proposals submitted under this Solicitation must be typed or printed using a standard Times New Roman, Arial or Calibri 12 point font, single-spaced and a blank line between paragraphs on 8-1/2” x 11” paper. Pages must be numbered, sections titled and printed back-to-back with a minimum of one-inch margins. Binders are preferred.

Number of Copies

Applicants must submit the original, five copies and one electronic copy on compact disc of the application and all required documents.

Packaging and Labeling

The original and copies of each volume must be labeled "SOLICITATION 000-00-000".

Include the following label information and deliver your application, in a sealed package:

Person’s Name Phone # Applicant’s Name Street Address City, State, Zip Code SOLICITATION 000-00-000 Contact

Preferred Method for Delivery

Applicant may deliver application by:

- U. S. Mail
- Hand delivery
- Courier service

Applications must be delivered to CDPH OHE Monday through Friday, 8 a.m. to 5 p.m., prior to the date and time specified in Section I.E. In accordance with Public Contract Code 10344, applications received after the specified date and time are considered late and will not be accepted. There are no exceptions to this law. **Postmark dates of mailing are not acceptable in whole or in part, under any circumstances**.

Organization of Application

Cover Letter (1 page maximum: Must be signed by an officer of the firm submitting the Application and include contact information. The cover letter must contain a commitment to provide the required services described with the personnel specified in the submission. The letter should certify that the information contained in the Application is true and correct.)
Required Documents Checklist, Attachment 1 Application Cover Page, Attachment 2
Narrative Must include answers to all questions, which must adhere to the stated page limit
Attachments: Attachment 3: Draft Budget Overview Attachment 4: Letters of Support Attachment 5: Cost Form Attachment 6: Business Information Sheet Attachment 7: HIPAA Compliance Form Attachment 8: Non-Supplantantion Certification Form

Nonprofit Organizations - A copy of a current IRS determination letter indicating nonprofit or 501 (c)(3) tax exempt status, if applicable.

B. PROCUREMENT ADMINISTRATION

1. Authority and Available Funding

This procurement will be conducted under the authority of the California Welfare and Institution Code Section 5814 and 5897. All disputes will be resolved by the Department of Public Health under such authority. The decisions of the CDPH Director are considered final.

The total amount payable for the agreement awarded under this Call for Applications shall not exceed $40,000. The agreement shall be for a term of 6 months.

The proposed agreement is valid and enforceable only if sufficient funds are made available by the Budget Act of the appropriate fiscal year for the purpose of the agreement. If full funding does not become available, CDPH will either cancel the resulting agreement or amend to reflect reduced funding and reduced activities.

2. Funding Restrictions

Funds may only be used for reasonable program purposes, including personnel, travel, supplies and services. Funds may not be used for construction or purchase of furniture.

3. Resolution of differences between Call for Applications and agreement language

If an inconsistency or conflict arises between the terms and conditions appearing in the final agreement and the proposed terms and conditions appearing in this Call for Applications, any inconsistency or conflict will be resolved by giving precedence to the agreement.

4. CDPH Rights

In addition to the rights discussed elsewhere in this Call for Applications, CDPH reserves the right to do any of the following:

- Cancel the Call for Applications.
- Modify any date or deadline appearing in this Call for Applications.
- Issue clarification notices, addenda, alternate Call for Applications instructions, forms, etc. If this Call for Applications is clarified, corrected, or modified, CDPH will post all clarification notices and/or Call for Applications addenda on BidSync.

5. Questions and Requirements Change Requests

Questions and requirements change requests must be directed to CRDPpilot@cdph.ca.gov**.** You may submit written questions and requirements change requests via email by the deadline specified in Section I. A.1. Responses will be posted on the CRDP website and BidSync in the timeline specified in Section I. A.1 Any verbal communication with CDPH OHE staff concerning this Call for Applications is not binding on the State and shall in no way alter a specification, term, or condition of the Call for Applications.

This Call for Applications includes a number of requirements on the Applicant, including format, content and qualifications. Potential Applicants may request requirements be changed if they believe they are inappropriate or unduly limit competition. Requests must be emailed to the address specified above and must be received by the date specified in Section I. A.1. Requests will be evaluated on a case-by-case basis.

Attachments

ATTACHMENT 1: REQUIRED DOCUMENTS CHECKLIST

Please ensure that each of the following required documents are included and check each box and sign the document to confirm its inclusion.

- ☐ Cover Letter
- ☐ Narrative
- ☐ Attachment 1: Required Documents Checklist
- ☐ Attachment 2: Application Cover Page
- ☐ Attachment 3: Draft Budget Overview
- ☐ Attachment 4: Letters of Support (Include form as cover page and letters)
- ☐ Attachment 5: Cost Form
- ☐ Attachment 6: Business Information Sheet
- ☐ Attachment 7: HIPAA Compliance Form
- ☐ Attachment 8: Non-Supplantation Certification

_____

Signed

_____

Date

ATTACHMENT 2: APPLICATION COVER PAGE

<table>
<tr><td colspan="5">A. Organization Name</td><td colspan="3">B. Primary Contact</td></tr>
<tr><td colspan="5"></td><td colspan="3"></td></tr>
<tr><td colspan="5">C. Address</td><td colspan="3">D. Phone Number</td></tr>
<tr><td colspan="5"></td><td colspan="3"></td></tr>
<tr><td colspan="5">E. City, State Zip</td><td colspan="3">F. Email</td></tr>
<tr><td colspan="5"></td><td colspan="3"></td></tr>
<tr><td colspan="8">G. Brief Description of Project</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="5">H. Target Population (Select only one)</td><td colspan="3">I. Geographic Target (Include county and any specific city or neighborhood targeted)</td></tr>
<tr><td>☐African American</td><td>☐Asian-Pacific Islander</td><td>☐Latino</td><td>☐LGBTQ</td><td>☒Native American</td><td colspan="3"></td></tr>
<tr><td colspan="5">J. Organizational Operating Budget</td><td colspan="3">K. Organization Type</td></tr>
<tr><td colspan="2">2013</td><td colspan="3">2014</td><td colspan="2">☐501 (c)3 Non-Profit</td><td>☐Government (Including Tribal)</td></tr>
<tr><td colspan="2"></td><td colspan="3"></td><td colspan="2">Note: only 501(c)3 Non-Profit and Government organizations are eligible to apply</td><td></td></tr>
</table>

ATTACHMENT 3: DRAFT BUDGET OVERVIEW

	6 Month Budget	Description
Program Budget		
Personnel		
Non-Personnel		
Direct Costs		
Indirect Costs @ 15% (rent excluded)		
Contracting Costs		
Evaluation Budget		
Grand Total	**$40,000**	
Annual Organizational Budget		
% of Organizational Budget		

ATTACHMENT 4: LETTERS OF SUPPORT

Please type or print a list of three (3) references that have provided letters of support for this application. The letters should be included in the response, following this form.

REFERENCE 1

Name, Title and Company of Reference			
Street address	City	State	Zip
Telephone number ( )			
Brief description of working relationship			

REFERENCE 2

Name, Title and Company of Reference			
Street address	City	State	Zip
Telephone number ( )			
Brief description of working relationship			

REFERENCE 3

Name, Title and Company of Reference			
Street address	City	State	Zip
Telephone number ( )			
Brief description of working relationship			

ATTACHMENT 5: COST FORM

Name of the Firm *(Legal name as it will appear on the agreement)*			
Mailing address	City	State	Zip Code
Telephone number ( )	Fax number ( )	Email address, if applicable	
Name of Contact Person	Telephone number: (If different from above) ( )		

Maximum Cost
Year One

Acknowledgment / Certification

The Applicant hereby certifies that the materials submitted in response to this Solicitation and the price(s)/rate(s) offered on this Cost Form are true and accurate to the best of the Proposer's knowledge.

The Applicant agrees that the price(s)/rate(s) offered herein shall remain in effect until CDPH awards the agreement and throughout the duration of the agreement. Any cost over runs or increases in services, if allowed, shall be billed at the price(s)/rate(s) stated for the appropriate budget period. Grant(s) extensions, if any, shall be billed at the price(s)/rate(s) stated for the last budget period/year if more than one budget period/year is shown.

The Applicant further understands that the above quoted rate(s) must include all of the costs including operating expenses, labor, service call charges, diagnostic fees/estimates, transportation/travel costs, mileage or per diem expenses, equipment costs, supplies, annual inflation costs/rate adjustments, profit margin, etc. By submitting this Cost Form the Proposer hereby claims its willingness to certify to and comply with all requirements and terms and conditions cited in this Solicitation and any attachment thereto.

The Applicant understands that its response will become a public document and will be open to public inspection.

Applicant's signature:	Date signed
Printed/typed name	Title

ATTACHMENT 6: BUSINESS INFORMATION SHEET

A signature affixed hereon and dated certifies compliance with all cost requirements. The signature below authorizes the State to verify the claims made on this form.

Name of the Firm:	CA Corp. No. (If applicable)	Federal ID Number

Name of Principal (If not an individual):	Title:	Telephone Number	Fax Number

Street Address / P.O. Box	City	State	Zip Code

Type of Business Organization / Ownership (Check all that apply)

Ownership
- ☐ Sole Proprietor
- ☐ Partnership
- ☐ Joint venture
- ☐ Association

Corporation
- ☐ Nonprofit
- ☐ For Profit
- ☐ Private
- ☐ Public

Governmental
- ☐ City/County, California State Agency, Federal Agency, State (other than California)
- ☐ Other: _____

Other Type of Entity
- ☐ Public or Municipal Corporation, School or Water District, California State College, University of California, Joint Powers Agency
- ☐ Auxiliary College Foundation
- ☐ Other: _____

California Certified Small Business Status ☐ N/A ☐ Microbusiness ☐ Small business ☐ NVSA

☐ Certified By DGS Certification No: _____ Expiration Date: _____

If certified, attach a copy of certification letter. If an application is pending, date submitted to DGS: _____

Small Business Type (If applicable) ☐ N/A ☐ Services ☐ Non-Manufacturer ☐ Manufacturer

☐ Contractor (Construction Type): _____ ☐ Contractor's License Type: _____

Veteran Status of Business Owner ☐ N/A (not a veteran or not certified by DGS)

☐ Disabled Veteran Certified by DGS Certification No. _____ Expiration Date: _____

If certified, attach a copy of certification letter. If an application is pending, date submitted to DGS: _____

Disadvantaged Business Enterprise Status: ☐ N/A ☐ Approved by the Cal Trans, Office of Civil Rights.

Certification number issued by Cal Trans: _____ Expiration Date: _____

Race/Ethnicity of Primary Business Owner ☐ N/A (No single owner possess more the 50% ownership)

Owner's Ethnicity (check one)
- ☐ Asian-Indian
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Pacific-Asian
- ☐ Other _____

Owner's Race (check one)
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other _____

If Asian, Native Hawaiian or Pacific Islander (check one):
- ☐ Asian-Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian
- ☐ Hawaiian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Samoan
- ☐ Vietnamese
- ☐ Other _____

Gender of Primary Business Owner ☐ N/A (Not independently owned) ☐ Male ☐ Female

Indicate possession of required licenses and/or certifications (if applicable): ☐ N/A (None required)

Contractor's State Licensing Board No.	PUC License Number CAL-T-	Required Licenses/Certifications (If applicable)

Signature	Date Signed

Printed/Typed Name	Title

Public Records Information

The above information is required for statistical reporting purposes. Completion of this form is mandatory. This information will be made public upon award of the contract(s) and will be supplied to department contract staff, Department of General Services and possibly other public agencies. To access contract(s) related records, contact the Contract Management Unit, 1501 Capitol Avenue, Suite 71.5178, MS 1802, P.O. Box 997377, Sacramento, CA 95899-7377 or call (916) 650-0100.

ATTACHMENT 7: HIPAA COMPLIANCE FORM

ATTACHMENT 8: NON-SUPPLANTATION CERTIFICATION FORM

As the duly authorized representative of _____, I hereby certify:
Organization Name

1. The funds allocated by the California Department of Public Health (CDPH) under the Capacity Building Pilot Projects grant program will not be used to supplant funding for existing levels of service and shall only be used for the purposes specified in the Call for Applicants.

2. Upon receipt, the funds will be deposited into an interest-bearing trust fund established solely for this purpose before the funds are transferred or expended for any of the purposes allowed in the Application and Budget, as approved by the CDPH. No CBPP funds are to be comingled with other funds.

Signature:	
Printed Name:	
Title:	
Phone:	
Date:	

ATTACHMENT 9: EVALUATION PLAN TEMPLATE

Evaluation Task	Person(s) Responsible	Timeframe
Staffing		
Engaging Stakeholders		
Focusing the Evaluation		
Gathering Credible Evidence		
Justifying Conclusions		
Using Evaluation Results		

Evaluation Plan Template Instructions

This evaluation plan template is based on the Capacity for Health template. The evaluation plan specifies evaluation activities and identifies individuals(s) responsible for the activity and a timeframe for completion. This template is provided for the convenience of the applicants. Applicants are free to modify or replace the template to best reflect the needs of its CDEP and target population.

Staffing: Provide steps necessary to identify, hire or otherwise engage staff necessary to plan and conduct the evaluation and fully integrate them into the CDEP

Engaging Stakeholders: Provide steps necessary to involve community stakeholders in every aspect of the evaluation process

Focusing the Evaluation: Provide steps necessary to identify the most critical aspects of the evaluation, identifying what will be measured and why, ensuring it is in line with community needs

Gathering Credible Evidence: Provide steps necessary for the systematic collection of data, including the data sources and the methods and other specifics of data collection

Justifying Evaluations: Provide steps necessary to ensure quality of data and to understand the context of results

Using Evaluation Results: Provides steps necessary to share results with others and to implement them within the organization to ensure continuous quality improvement

For more detailed information, see Developing an Evaluation Plan, Hosted by C4H, available here: http://www.apiahf.org/sites/default/files/Developing%20an%20Evaluation%20Plan%20Presentation%20Slides.pdf

ATTACHMENT 10: CRDP PHASE 2 BACKGROUND

The California Reducing Disparities Project (CRDP) is a project of the California Department of Public Health's Office of Health Equity. CRDP is funded by the Mental Health Services Act (MHSA) of 2004 to support and strengthen mental health programs in California.

MHSA

California voters passed Proposition 63 (now known as the MHSA) in November 2004. The MHSA provides increased funding, personnel and other resources to support mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system.

The MHSA allocates 20% of the Mental Health Services Fund for Prevention and Early Intervention (PEI) as a key strategy to prevent mental illness from becoming severe and disabling and improve timely access for underserved populations. PEI programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness, including suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from their homes.

Mental Health Disparities

The CRDP was developed in response to the disparities that exist in mental health care for diverse populations. Mental health disparities are well documented, especially as they relate to access, availability, quality and outcomes of care. Two major reports identified mental health disparities among racial/ethnic population groups as a national problem (Mental Health: Culture, Race and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General (DHHS, 2001) and The President's New Freedom Commission on Mental Health's Report Achieving the Promise: Transforming Mental Health Care in America (DHHS, July 2003)). Continuing disparities are troubling, particularly given California's diversity and large populations suffering from these disparities.

Populations targeted by the CRDP are unserved, underserved or inappropriately served in the mental health system (DHHS, 2003). Collectively, racially and ethnically diverse populations experience a greater disability burden from emotional and behavioral disorders. According to the report, "The mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them." Additionally, "racial and ethnic minorities bear a greater burden from

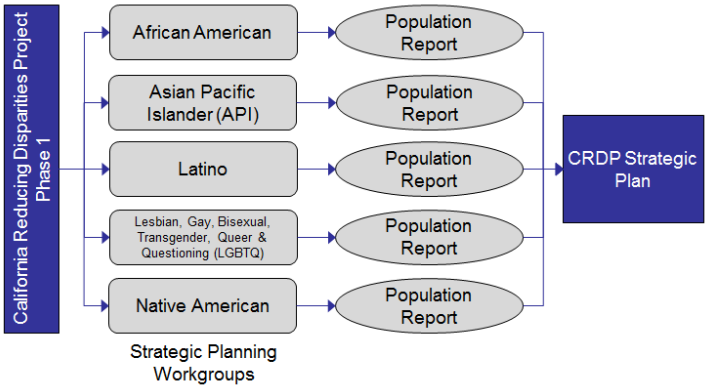
unmet mental health needs and thus suffer a greater loss to their overall health and productivity" (DHHS, 2001). These disparities have been attributed to an inadequate ability of publicly funded mental health systems to understand and value the need to adapt service delivery processes to the histories, traditions, beliefs, languages and values of diverse groups (DHHS, 2001). This inability results in misdiagnosis, mistrust and poor utilization of services by ethnically/racially diverse populations (Snowden, 1998; Takeuchi, Sue, & Yeh, 1995).

CRDP

Funded by the MHSA and seeking to answer former U.S. Surgeon General David Satcher's call for national action to reduce mental health disparities, the CRDP was launched in 2009 by the former California Department of Mental Health. The CRDP consists of two phases. Phase 1, to be completed in 2015, focuses on the development of a strategic plan to reduce mental health disparities, while Phase 2, to be completed in or about 2020, focuses on implementation of the CRDP strategic plan.

CRDP Phase 1

In Phase 1, each of the five targeted populations (African American; Asian Pacific Islander; Latino; Lesbian, Gay, Bisexual, Transgender and Queer/Questioning; and Native American) established a Strategic Planning Workgroup (SPW), which in turn engaged community members in an effort to identify promising Community-Defined Evidence Programs (CDEP) and recommendations for reducing mental health disparities for that population. The findings from each SPW's community engagement process were compiled into a Population Report. The Population Reports were then compiled into a single, comprehensive (draft) Strategic Plan. The Population Reports and Draft Strategic Plan are available in the Bidder's Library. This process is outlined in the figure below. The strategic plan has two primary components: 1) goals and strategies to reduce mental health disparities in California; and 2) recommendations to CDPH on what CRDP Phase 2 should look like and how Phase 2 funding should be used.



As part of Phase 1, the California MHSA Multicultural Coalition (CMMC) was formed in 2011 to integrate cultural and linguistic competence into the public mental health system. The Coalition provides information to educate key stakeholders and policy decision makers on issues surrounding mental health in historically unserved, underserved and/or inappropriately served communities. Moreover, the Coalition is tasked with increasing awareness regarding mental health disparities in general.

CRDP Phase 2

CRDP Phase 2 is designed to build on and implement strategies developed in Phase 1 and identified in the CRDP Strategic Plan. Phase 2 focuses on strengthening and demonstrating effectiveness of population-specific interventions and developing and reinforcing infrastructure to effectively deliver mental health services to impacted populations.

CRDP Phase 2's vision is a California in which all individuals, regardless of race, ethnicity, sexual orientation or gender identity, receive quality mental health prevention and treatment services delivered in a culturally and linguistically competent manner. Its goals include:

- Demonstrate through a rigorous, community participatory evaluation process that selected community-defined evidence programs are effective in preventing or reducing the severity of mental illness
- Increase funding of validated community-defined evidence programs by other, non-CRDP sources, including county mental health agencies
- Support changes in statewide and local mental health delivery systems and policies that will reduce mental health disparities among unserved, underserved and inappropriately served populations

CRDP Phase 2 is guided by the following principles, which serve as the basis for its structure and framework:

- **Do business differently.** Doing business differently has been a focus of CRDP from the start. Doing business differently involves attentive listening and genuine consideration of community and CRDP partner input in order to be responsive to community needs. Doing business as usual has contributed to disparities; therefore, reducing disparities will need to involve doing business differently.
- **Build community capacity.** To sustain efforts to reduce mental health disparities beyond the period of CRDP Phase 2 funding, it is necessary to invest in creating community structures and supporting community-based organizations.
- **Fairness.** A program designed to reduce disparities must not perpetuate disparities. Contracts should be awarded based on merit and only after all

interested parties have been invited to apply and if needed, provided with tools and services to support their application.

- **System change.** CRDP does not exist in a vacuum. If the effort to reduce disparities begun with CRDP Phases 1 and 2 is to be sustained beyond the period of funding, then Phase 2 needs to address the context and bigger picture within which CRDP exists. This will allow smoother integration of Phase 2 funded programs into the larger mental health care delivery system.

There are five elements to Phase 2:

- Pilot Projects – Pilot Projects are the central component of CRDP Phase 2. Pilot Projects are existing Community-Defined Evidence Projects (CDEPs) that are providing culturally competent prevention and early intervention services to members of a CRDP target population. CDEPs include sets of practices that communities have used and determined to yield positive results as determined by community consensus over time, that may or may not have been measured empirically but have reached a level of acceptance by the community (Community-defined Evidence Project Working Group, 2007). Phase 2 funds would allow a CDEP to expand to reach more clients, build its capacity and be rigorously evaluated to determine its effectiveness. Pilot Projects may include projects identified in the Population Reports, as well as additional projects that may not have been included in the Phase 1 process, but show promise of effectively addressing mental health. We are defining mental health loosely to allow for holistic approaches that have proven effective.
  Validation of CDEPs is important because many funding and reimbursement opportunities are tied to evidence-based practices. Validating CDEPs can help them be established as evidence-based practices. Evidence-based practices are approaches to prevention or treatment that are validated by some form of documented scientific evidence. This includes findings established through controlled clinical studies, but other methods of establishing evidence are valid as well. Seeking recognition as an evidence-based practice will be optional for pilots, as it may not be appropriate for all populations and/or pilots.
  There will be two stages for the Pilot Project component. Stage one is Capacity Building and lasts six months. Projects will be selected based on need, potential and likelihood for success. Through the Capacity Building process, they will be provided with technical assistance and training in order to develop organizational capacity to apply for Implementation Pilot Project grants. Stage two is Implementation. During the Implementation stage, Pilot Projects will expand, implement and evaluate their CDEP. All Pilot Projects will be selected through a competitive process, based on the review of their applications.
- CRDP Advisory Committee – In Phase 2, the CRDP Advisory Committee will consist of representatives from communities around the state. It will advise CDPH CRDP

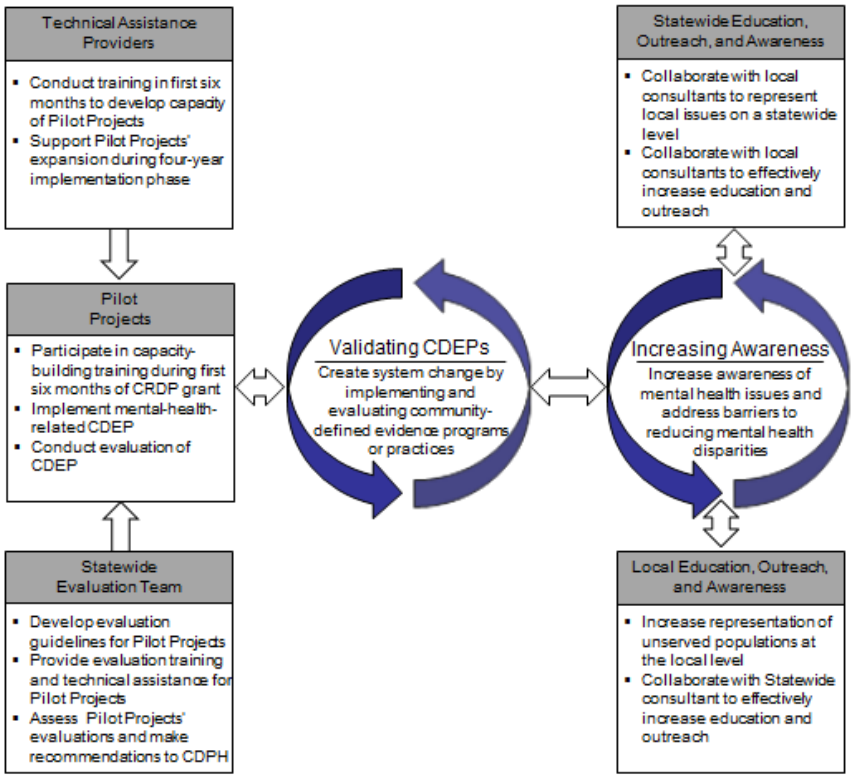
staff on community needs and best practices to guide the integration of cultural and linguistic competence into the public mental health system.

- Education, Outreach and Awareness Consultants – In CRDP Phase 2, education and outreach regarding the needs of underserved communities and effective strategies to address these disparities will be bolstered at the statewide and local levels. One statewide consultant and up to five local consultants will be engaged to help bring together community stakeholders and resources to address mental health disparities. The Local Education, Outreach and Awareness Consultants will work to increase awareness of mental health issues in impacted communities and inform local policy makers and administrators about issues impacting unserved, underserved and inappropriately served communities. In addition, the local education and outreach providers will seek to identify and implement collaborative processes through which representatives from the impacted communities can more effectively work with county administrators to reduce mental health disparities by increasing access to care and improving quality of care and service outcomes.
- Technical Assistance – Five population-specific Technical Assistance (TA) Providers will be established in CRDP Phase 2. During the Capacity Building stage, the TA Providers will be expected to work with Pilot Projects to develop their administrative and programmatic capacities and support them in their application process for the CRDP Phase 2 Implementation Pilot Projects. During the Implementation phase, the TA Providers will focus on supporting the Pilot Projects by working to improve administration and operations, identifying and securing additional resources and building strategic partnerships to better serve communities.
- Evaluation – The purpose of Phase 2 evaluations is to demonstrate the effectiveness of CDEPs, to help Pilot Projects improve operations and interventions and to determine the overall effectiveness of CRDP in reducing mental health disparities in the target populations. Evaluations will be performed by a Statewide Evaluation Team and by evaluators at each Pilot Project and will be organized at three levels:
  1) Individual pilot programs supported by the Statewide Evaluation Team will evaluate their projects to determine the effectiveness of interventions in preventing and/or reducing the severity of mental illness and/or promoting mental health in the communities that they are serving;
     . “Promoting mental health” is a deliberately broad term used to encompass a broad variety of potential holistic strategies that go beyond traditional behavioral health and address mental health as affirmative mental wellness, rather than simply the absence of mental disease.
  2) Population leads from the Statewide Evaluation Team will prepare guidelines to ensure a certain level of consistency across the Pilot Projects for each population group. This will include common outcome measures and evaluation methods/approaches; and

3) Every component of the CRDP (including Pilot Projects, Technical Assistance Providers, etc) will be assessed by the Statewide Evaluation Team to determine if each individual component and the CRDP taken in whole are effective in addressing mental health disparities.

Though the Phase 2 Pilot Project evaluations will be managed and owned by the individual Pilot Projects, the Statewide Evaluation Team will be responsible for providing guidance and support to each of the Pilot Projects to develop appropriate community participatory evaluations as defined by their respective communities. The Statewide Evaluation Team will provide Pilot Projects with technical assistance & training related to evaluation.

The image below illustrates the relationship between these elements:



CRDP Phase 2 is anticipated to be funded at $60 million and allocated between the Contractors as follows:

Element	Total Funding	Number of Contracts/ Grants	Funding Term	Maximum Funding per Contract per Year
Local Education, Outreach and Awareness Consultants	$2,000,000	5	4 years	$250,000
Statewide Education, Outreach and Awareness Consultant	$1,000,000	1	4 years	$250,000
Pilot Projects *Capacity Building* *Implementation*	$600,000 $39,900,000	15 35	6 months 4 years	$40,000 $285,000
Technical Assistance Provider	$6,250,000	5	5 years	$250,000
Statewide Evaluation Team - Evaluation TA - Overall Evaluation	$6,000,000 $4,250,000	1	5 years	$1,200,000 $500,000

Proposers may respond to multiple CRDP Phase 2 component solicitations. However, no organization shall be awarded multiple CRDP Phase 2 grants.

Native American Community

California has the nation's largest Native American population, with over 352,000 residents in the 2010 Census, with the largest portion in Los Angeles County. California's Native American population is the most diverse in the nation, with over 100 federally recognized tribes. In addition, many unrecognized tribes suffer from even greater disparities. Prior to European contact, over 500 distinct groups existed in California, speaking over 300 dialects.

Native Americans in California reside in metropolitan/urban, rural, and tribal reservation communities, all of which have unique challenges to mental health. Today, most live in urban areas and Native Americans have relatively little tribal land in California.

Summary of Mental Health Status

Federal and local policies have governed the quality of life for Native Americans over the past 400 years. These government policies never had wellness as a goal or a strategy for Native Americans. In fact, the opposite was true; federal policies were initially directed at the extermination of Native Americans through genocide, criminalization, and displacement. The reservation system was then implemented, creating a dependence on government for basic life needs such as food and clothing.

Assimilation efforts followed, displacing Native Americans, in early years into boarding schools and later into urban areas, forcing them to reject their culture and history and adapt to white society. "Kill the Indian, Save the Man" was an early motto for these efforts.

Further disparities stem from a mental health system that is an outcropping of the American mainstream culture centered on the beliefs, norms, and values of white Americans. As such, the mental health system is not equipped or trained to deal with the mental health concerns of ethnic groups.

Additionally, clinicians are rarely trained to take the stressful events of racism, discrimination, and genocide into consideration when drafting a diagnosis. Studies have shown that racism and discrimination are clearly stressful events that have physical and psychological impacts on the people who experience them, directly placing these people at increased risk for a large range of health disparities.

Summary of Native American Strategic Planning Workgroup (SPW)

The Native American SPW was led by The Native American Health Center. The 8-member Native American Strategic Planning Workgroup Advisory Committee guided the project "in a good way" and represented the project statewide. The workgroup is made up of Native American behavioral health professionals from across the state of California. The SPW met over the course of two years and gathered input from community members around the state.

American Indians and Alaska Natives in California have elevated rates of poverty, violence, substance abuse, depression, and other psychological maladies when compared to non-Hispanic whites. It is essential to understand these factors are co-occurring, meaning that a Native American person is simultaneously at risk for all of these factors, creating a potentially severe web of social and psychological risks that

impact mental well-being. In addition, California Native Americans show significantly more difficulty than non-Hispanic whites when receiving or accessing mental health care.

The long history of oppression of tribal traditions and culture has had a devastating effect on the mental health of Native Americans. Many cultural practices were historically driven underground due to persecution by the dominant society. This history including colonization, outlawing indigenous tribal languages and spiritual practices, and centuries of forced relocation, has warranted mistrust of government programs and health institutions.

The SPW highlighted 22 community-defined practices that improve behavioral health in California Native Americans and recommended four principles for alleviating disparities:

1. Respect the sovereign rights of tribes, and urban American Indian health organizations to govern themselves.
2. Support rights to self-determination for tribes and urban American Indian health organizations to determine and implement programs and practices that will best serve their communities.
3. Value Native American cultural practices as stand-alone practices, validated through community defined evidence.
4. Incorporate the use of Native American specific research and evaluation methods unique to each community.

This summary is based on the CRDP Phase 1 Native American Strategic Planning Workgroup report, “Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans: California Reducing Disparities Project, Native American Strategic Planning Workgroup Report.” (Native Vision Project, 2012)

ATTACHMENT 11: IPP GOALS & REQUIREMENTS

Goal 1: Evaluate CDEP Effectiveness

Evaluation is a cornerstone of the success of the IPPs. Rather than imposing a top-down, one-size-fits-all approach, IPPs will be empowered to develop their own approach to program evaluation in a manner that is culturally and linguistically competent. Working under the guidance of the Statewide Evaluation Team, the Grantee will refine its Proposed Evaluation Plan and implement its approved Evaluation Plan throughout the term of the grant. Over the course of the grant, the IPPs will be responsible for collecting data, providing regular updates to CDPH and developing a final Evaluation.

Requirements:

B. Evaluation Plan

As part of its application, the Grantee will have provided a detailed Proposed Evaluation Plan. An optional template is provided as a guide in Attachment 11. However, IPPs may amend or replace it as appropriate for their program. The Centers for Disease Control's "Developing an Effective Evaluation Plan" is also provided in the Bidder's Library and may be a useful reference in developing the Proposed Evaluation Plan. The Evaluation Plan shall include a detailed description of the following:

1. Evaluation Approach: This describes specific details in regards to how the Grantee would implement a program evaluation that is both culturally and linguistically competent and addresses the needs of the community that it is serving. The approach must describe in detail the plan for gathering qualitative and quantitative data and must detail how community stakeholders would be engaged throughout the evaluation process.
2. Theory of Change and Logic Model: The Theory of Change is a detailed description of the step-by-step process that theoretically will lead to the end goal, including a clear articulation of the assumptions made to explain the change process. The Logic Model is a planning tool that provides detailed description of how the program is expected to improve mental health outcomes of program participants. Samples of the Theory of Change and Logic Model are provided in the Bidder's Library.
3. Key Questions and Outcome Measures: This should include the specific, detailed questions the evaluation will seek to answer and what outcomes will be tracked. This must include mental health outcomes for individuals at increased risk of mental illness or with recent onset of mental illness.

4. Timeline: This should include planned due dates for included requirements and milestones that show tangible process towards meeting each requirement.
5. Evaluation Staffing Model: If the Grantee proposes to utilize an in-house staff evaluator, the Grantee shall provide a description of the key qualifications and essential duties of the principal evaluator. In the event that the Grantee proposes to utilize a contractor to meet its evaluation requirements, the Grantee must provide the contractor's:
    i. Statement of qualifications, which demonstrates the Contractor's to develop and implement an evaluation plan, working in a culturally and linguistically competent manner and engaging the community throughout the process
    ii. Detailed statement of work, which demonstrates the ability of the Grantee to ensure effective and timely implementation of the Evaluation Plan
6. Continuous Quality Improvement Plan: The Grantee must provide a detailed plan indicating how the results will be operationalized within the organization to ensure continuous quality improvement. This should include:
    i. Who within the organization will be involved?
    ii. When and how often will results be reviewed?
    iii. Who will decide how programs should be changed as a result of the evaluation?
    iv. Which stakeholders will be involved and in what setting? (Stakeholders include any persons interested in or impacted by the CDEP, including clients, family members and other community members.)
    v. How will stakeholder feedback be incorporated?
7. Update Plan: The Grantee shall update the Evaluation Plan annually, review with the Statewide Evaluation Team and obtain approval for any deviations from CDPH. The applicant must provide a detailed plan indicating how the Evaluation Plan will be updated and reviewed to meet this requirement at least once every grant year.
8. Institutional Review Board (IRB) Review (If necessary): IPPs may be required to obtain IRB approval if the evaluation is deemed to constitute "human subject research" (see http://www.hhs.gov/ohrp/humansubjects/commonrule/ for more information). If the Grantee has determined that it will need IRB approval, the Proposed Evaluation Plan should reflect this requirement. The Statewide Evaluation Team will independently make a recommendation to CDPH as to which IPPs must pursue IRB approval.

9. Evidence-Based Practice (Optional): The Applicant may wish to pursue review and acceptance as an Evidence-Based Practice, at its option. Doing so would require experimental or quasi-experimental evaluation design. The Grantee should review requirements from Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices (http://www.nrepp.samhsa.gov/). If the Applicant plans to pursue review and acceptance, it must provide a detailed description of how it would meet the requirements.

C. Within 30 days of the grant being initiated, the IPP will receive Evaluation Guidelines from the Statewide Evaluation Team and meet to discuss evaluation strategies, identify opportunities for refinement and ensure alignment of the Proposed Evaluation Plan with the Evaluation Guidelines and to ensure it fulfills all data collection needs for the CRDP Program Evaluation. The Grantee shall revise the Plan, as appropriate, and resubmit it for review and acceptance by CDPH within 90 days of the start of the grant period. Failure to secure acceptance by CDPH are grounds to suspend grant until the requirement has been met. CDPH will have the sole discretion to accept or reject the Evaluation Plan. Participation in Ongoing Evaluation Technical Assistance

   The Statewide Evaluation Team will provide IPPs with ongoing technical assistance. This technical assistance will include, at a minimum:

   - Evaluation planning, design and implementation, measuring the baseline, data collection, engaging community members in the evaluation process, seeking recognition as an evidence-based strategy, hiring an evaluator and obtaining Institutional Review Board approval of research protocols (if necessary). The Evaluation Technical Assistance provider will also provide ongoing support throughout the implementation stage to help refine and troubleshoot issues that may arise regarding evaluation. This may include, but is not limited to, assistance regarding data collection, interpretation and validation.

D. Annual Evaluation Updates

   At the end of each grant year, the Grantee shall provide an Annual Update to CDPH. This report shall include an overview of yearly data, provide a recap of activities during the year and an overview of the activities planned for the upcoming year. In addition, it should include a narrative description of evaluation successes and challenges to the extent available. The update shall be provided within 60 days of the end of the year.

E. Updated Evaluation Plan

The Grantee shall submit an Updated Evaluation Plan by the end of each grant year to account for program insights obtained during the previous year, additional guidelines issued by CDPH, the Statewide Evalution Team or new circumstances. CDPH will have the sole discretion to accept or reject the Updated Evaluation Plan.

F. CDEP Evaluation

No later than the end of the second quarter of the fourth grant year, the Grantee shall submit to the Statewide Evaluation Team a draft version of its Final CDEP Evaluation. The Statewide Evaluation Team shall provide feedback and recommendations. The Grantee shall then revise the Evaluation as appropriate. Implementing feedback and recommendations shall occur at the Grantee's sole discretion; however, the Statewide Evaluation Team will also be providing subject matter expert support to CDPH staff in reviewing the Final Evaluation.

Prior to the end of the grant period, the Grantee shall provide a Final Evaluation that details the results and impacts of the Pilot Project. The Final Evaluation shall be based on the Evaluation Plan, which shall be aligned with all Evaluation Guidelines provided by the Statewide Evaluation Team. CDPH will have the sole discretion to accept or reject the Final CDEP Evaluation.

Goal 2: Increase CDEP Scale to Facilitate Evaluation

CDEP validation as an effective practice relies on achieving an appropriate sample size. Grantees will receive guidance on appropriate sample size from the Statewide Evaluation Team. Grantees that have not already achieved adequate scale to provide an appropriate sample size will be responsible for increasing its current project scale to allow for effective evaluation, through the manner established by its application. To support responsible, effective expansion, Pilot Projects will receive resources, guidance and technical assistance from CDPH and its contractors.

<u>Requirements:</u>

A. CDEP Growth Plan

Within 60 days of the grant being initiated, the Statewide Evaluation Team will provide a written assessment of each IPP's need to increase scale to facilitate evaluation. Based on the identified need, the IPP will work the Native American TA Provider to identify appropriate strategies to achieve this scale. The IPP will produce an Action Plan that will meet the assessed needs, which must be finalized within 90 days of receipt of the written assessment.

Goal 3: Strengthen Operations and Infrastructure to Improve Organizational Sustainability

TA will be provided to Grantees in order to build organizational capacity. The TA will serve to remove any obstacles related to organizational capacity that might cause an IPP to be unsuccessful. In addition, this TA will work to make grantees more sustainable. Sustainability includes developing the capacity to apply for future grants and other funding streams, the organizational structure to facilitate growth and other infrastructure that will help grantees provide service at the highest level.

In order to achieve this, IPPs will be working closely with the Native American TA Provider. The TA Provider will provide specific support to all IPPs as well as support tailored to each IPP's individual needs. The IPPs will be required to participate in technical assistance activities, including an initial assessment, planned technical assistance trainings and ongoing technical assistance and to provide input, as necessary, to facilitate tailored support. In addition, the IPPs will receive TA from TA Providers focused on other populations, to support the IPPs in better serving LGBTQ and mixed race individuals. Technical assistance will include, but is not limited to:

- Community Engagement
    - Community outreach
    - Cultural competence
    - Linguistic competence
- Organizational Development
    - Grant writing
    - Financial planning and management
    - Organizational planning and management
    - Staff development
    - Board development
    - Professional networking
    - Regulatory compliance
    - Information technology
- Program Development
    - Continuous quality improvement

<u>Requirements:</u>

A. CDEP Capacity Building Action Plan

Within 60 days of the grant being initiated, the Native American TA Provider will provide a written assessment of each Native American IPP's organizational strengths and limitations in effectively and efficiently providing its CDEP. We expect the written assessment to be developed through a collaborative process in which the Native American TA Provider and the IPP will work to identify any current gaps. The IPP will produce an Action Plan that will meet the assessed needs, which must be finalized within 60 days of receipt of the written assessment.

B. Peer-to-Peer Learning

CDPH, supported by the five TA Providers will organize an annual in-person peer-to-peer learning session for all pilot projects. **Grantees are required to attend in-person each year and participate and should budget for travel costs for three staff.**

Goal 4: Increase Awareness of CDEPs

Increasing awareness of effective mental health practices in the Native American, mental health provider, funder and policy communities is critical to increasing adoption of such practices.

In order to facilitate dissemination of IPP results, there will be a Final Convening. The Statewide Evaluation Team and Native American TA Provider will organize a symposium featuring the successes and the lessons learned from all Native American Pilot Projects. Each IPP will participate in the planning and execution of this symposium.

Requirement:

A. Draft Presentation

Grantee shall work with the TA Provider and the Statewide Evaluation Team to identify the appropriate format and content for its presentation. Grantee shall develop a PowerPoint presentation covering its success and lessons learned, in the context of the overall Native American efforts. The Draft shall be completed at least 30 days prior to the Final Convening. Draft shall be reviewed by CDPH, the Native American TA Provider and the Statewide Evaluation Team.

B. Final Presentation

Grantee shall refine its presentation, as appropriate, and present at the Final Convening. Grantee shall provide CDPH with a copy of the presentation as the

final requirement. The Final Presentation shall be provided to CDPH no later than 10 days prior to the Final Convening.

Goal 5: Project Management

Effectively implementing these grants will require regular meetings and updates between the Grantee and CDPH. This will ensure CDPH is up-to-date on IPP progress and allow Grantees to provide feedback on the support they are receiving.

Requirement:

G. Kickoff Meeting

The Grantee shall attend a kickoff meeting with the CDPH OHE Grant Manager (GM). The Grantee's Project Manager (PM), Grant Administrator and Fiscal Officer shall attend this meeting to discuss the administrative, fiscal and technical aspects of this contract. Prior to the kickoff meeting, the GM will develop an agenda, which the PM may add to, as necessary. The PM will provide an agenda to all potential meeting participants. CDPH OHE will designate the date and location of this meeting. **Grantees are required to attend in-person and participate and should budget for two days of travel costs for three staff.**

The meeting shall include, but is not limited to, a review of the following:

a. Administration;

b. Detailed review of the Work Plan, schedule and requirements;

c. Roles and responsibilities; and

d. Strategies and goals.

H. Quarterly Collaboration Meetings

The Grantee shall meet with CDPH staff and other CRDP contractors/grant recipients at least quarterly. It is anticipated that these sessions will last two hours and will be held electronically.

I. Quarterly Update

No later than 15 days after the close of each quarter the, Grantee shall provide a written update on its program. This update shall cover progress in implementing the Work Plan and Evaluation Plan, including achievement of the Goals and Objectives therein. The report must have a separate section covering each of the goals, each a minimum of two pages and a maximum of ten pages for the entire update.

For Goal 1 the section shall provide an update on overarching and IPP specific program metrics, following the guidelines specified by the Statewide Evaluation Team. The report shall also include a discussion of any notable experiences or challenges in evaluation or data collection during the period. The Grantee must maintain records detailing the data collected and must make files available for inspection upon request.

For Goals 2 through 5 the report shall focus on progress completing activities and achieving objectives included in the Work Plan for each Goal, and may include notable experiences, key performance indicators and/or technical assistance needs as well. These periodic reports may be augmented by informal telephone, email or in-person reports, as needed.

J. Closeout Meeting

The Grantee shall compile a closeout report that summarizes the major efforts, findings and lessons learned from CRDP Phase 2 from the perspective of the IPP. The Grantee shall deliver the closeout report in person during a meeting with CDPH OHE to ensure thorough knowledge transfer. The Final Meeting must be completed before the end of the term of this Agreement. The PM will determine the appropriate meeting participants and particulars. **Grantees are required to attend in-person and participate and should budget for travel costs for three staff.**

ATTACHMENT 12: DEFINITION OF TERMS

Capacity Building: The process by which individuals, groups, organizations, institutions and societies increase their abilities to: (a) perform core functions, solve problems, define and achieve objectives; and (b) understand and deal with their development needs in a broad context and in a sustainable manner. (United Nations Educational, Scientific and Cultural Organization, 2006)

Community-Defined Evidence Practice: A set of bottom-up practices derived from a community's ideas of illness and healing or positive attributes of cultural or from traditional practices. In addition, the practice has been used by the targeted community, which has determined it to yield positive results through community consensus. While some CDEPs may have been measured empirically, this is not necessary to show that there is a consensus in the community regarding its effectiveness. CDEPs can include a range of culturally tailored treatment approaches or support (Martinez, 2010; CIBHS, 2014; Community Defined Evidence Project Work Group, 2007). These services are often culture-specific practices that are supported by community experience but not yet recognized or funded by the public mental health system.

Community-Participatory Evaluation: A partnership approach to evaluation in which stakeholders actively engage in developing the evaluation and all phases of its implementation.

Those who have the most at stake in the program – partners, program beneficiaries, funders and key decision makers – play active roles. Participation occurs throughout the evaluation process, including:

- Identifying the relevant questions;
- Planning the evaluation design;
- Selecting the appropriate measures and data collection methods;
- Gathering and analyzing data;
- Reaching consensus about findings, conclusions and recommendations; and
- Disseminating results and preparing an action plan to improve program performance. (Zukoski & Luluquisen, 2002)

Cultural Competence: Cultural competence is a set of congruent behaviors, attitudes, policies, structures and practices that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations. The word "culture" is used to imply the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. The word competence is used because it implies having the capacity to function effectively. A

culturally competent system of care, agency or organization acknowledges and incorporates—at all levels. (Cross, 1989)

Culture: An integrated pattern of human behavior which includes thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, role, relationships and expected behaviors of a racial, ethnic, religious or social group and the ability to transmit this pattern to succeeding generations. (National Center for Cultural Competence, 2001)

Disparities, Mental Health: Differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment or geographic location or the combination of any of these factors. (Health and Safety Code, Section 131019.5)

Ethnicity: Of or relating to large groups of people classed according to common racial, tribal, religious or linguistic or cultural origin or background. (National Center for Cultural Competence, 2001)

Intervention: Any type of treatment, preventive care or test that a person could take or undergo to improve health or to help with a particular problem. (Agency for Healthcare Research and Quality)

Linguistic Competence: Linguistic competence is the capacity of an organization and its personnel to effectively communicate with persons of limited English proficiency, those who have low literacy skills or are not literate and individuals with disabilities. These may include, but not limited to, the use of: bilingual/bicultural staff; cultural brokers; multilingual telecommunication systems; teletypewriter; foreign language interpretation services; sign language interpretation services; ethnic media in languages other than English; print materials in easy to read, low literacy, picture and symbol formats; assistive technology devices; computer assisted real time translation; materials in alternative formats; varied approaches to sharing information with individuals who experience cognitive disabilities; and translation of legally binding documents, signage, health education materials and public awareness materials and campaigns. The organization must have policy, structure, practices, procedures and dedicated resources to support this capacity. (National Center for Cultural Competence, 2001)

Mental Illness: Disorders generally characterized by dysregulation of mood, thought, and/or behavior, as recognized by the Diagnostic and Statistical Manual, 4th edition, of the American Psychiatric Association (DSM-IV). (CDC, 2013)

Prevention: A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this program is to bring

about mental health including reduction of the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is significantly higher than average and, as applicable, their parents, caregivers, and other family. “Risk factors for mental illness” means conditions or experiences that are associated with a higher than average risk of developing a potentially serious mental illness. Kinds of risk factors include, but are not limited to, biological including family history and neurological, behavioral, social/economic. Examples of risk factors include, but are not limited to, a serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, prolonged isolation, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness. Prevention program services may include relapse prevention for individuals in recovery from a serious mental illness. Prevention programs may include universal prevention efforts as defined below if there is evidence to suggest that the universal prevention effort is likely to bring about mental health and related functional outcomes for individuals and members of groups or populations whose risk of developing a serious mental illness is significantly higher than average. Universal prevention efforts mean efforts that target a population that has not been identified on the basis of risk. (MHSOAC, 2014)

Early Intervention: Treatment and other services and interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) that result from untreated mental illness. Early Intervention program services shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years. Early Intervention program services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness, as applicable. Early Intervention program may include efforts to prevent relapse in an individual with early onset. (MHSOAC, 2014)

Race: There is an array of different beliefs about the definition of race and what race means within social, political and biological contexts. The following definitions are representative of these perspectives:

- A tribe, people or nation belonging to the same stock; a division of humankind possessing traits that are transmissible by descent and sufficient to characterize it as a distinctive human type.

- Race is a social construct used to separate the world's peoples. There is only one race, the human race, comprised of individuals and characteristics that are more or less similar to others. (National Center for Cultural Competence, 2001)

Sustainability: Developing the capacity to apply for future grants and other funding streams, the organizational structure to facilitate growth and other infrastructure that will help grantees provide service at the highest level.

Target Populations: The specific population groups that the program is attempting to impact.

ATTACHMENT 13: REFERENCES

Agency for Healthcare Research and Quality. Effective Health Care Program Definitions, retrieved from: http://effectivehealthcare.ahrq.gov/index.cfm/glossary-of-terms/.

Aguilar-Gaxiola, S., Loera, G., Méndez, L., Sala, M., Latino Mental Health Concilio, and Nakamoto, J. (2012). Community-Defined Solutions for Latino Mental Health Care Disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup Population Report, retrieved from: http://www.cdph.ca.gov/programs/Documents/Latino_Population_Report.pdf

Community-defined Evidence Project Working Group (2007) (2009) Community Defined Evidence Project: Research from the Ground Up

Cross, T.L., et al (1989) Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed, retrieved from: http://gucchd.georgetown.edu/72808.html.

Department of Health and Human Services, Office of the Surgeon General (2001) Mental Health: Culture, Race and Ethnicity A Supplement to Mental Health: A Report of the Surgeon General, retrieved from: http://www.ncbi.nlm.nih.gov/books/NBK44243/.

Department of Health and Human Services, The President's New Freedom Commission on Mental Health (2003) Achieving the Promise: Transforming Mental Health Care in America, retrieved from: http://store.samhsa.gov/product/Achieving-the-Promise-Transforming-Mental-Health-Care-in-America-Executive-Summary/SMA03-3831.

Department of Health and Human Services, Child Welfare Information Gateway, FRIENDS National Resource Center for Community-Based Child Abuse Prevention, & Center for the Study of Social Policy-Strengthening Families (2011) Strengthening Families and Communities: 2011 Resource Guide, retrieved from: https://www.childwelfare.gov/pubs/guide2011/guide.pdf.

Department of Mental Health (2008) Proposed Guidelines, Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan

Martinez, K., Callejas, L.M., & Hernandez, M. (2010) Community-Defined Evidence: A "Bottom Up" Behavioral Health Approach to Measure "What Works" in Latino Communities. Report on Emotional & Behavioral Disorders in Youth.

Mental Health Services Act (2004) retrieved from: http://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx.

Mikalson, P., Pardo, S. and Green, J. (2012) First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California. Retrieved from: http://www.cdph.ca.gov/programs/Documents/LGBTQ_Population_Report.pdf

Mental Health Services Oversight & Accountability Commission (2014) MHSA Prevention and Early Intervention Proposed Regulations

National Center for Cultural Competence (2001) Definitions of culture, retrieved from: http://www.nccccurricula.info/culturalcompetence.html

Native Vision Project (2012) Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans: California Reducing Disparities Project, Native American Strategic Planning Workgroup Report. Retrieved from: http://www.nativehealth.org/sites/dev.nh.edeloa.net/files/native_vision_report_compressed.pdf

Pacific Clinics (2013) Asian Pacific Islander Population Report: In Our Own Words. Retrieved from: http://crdp.pacificclinics.org/resources/crdp/document/crdp-api-population-report-our-own-words

Snowden, L.R. (1998) Racial differences in informal help seeking for mental health problems. Journal of Community Psychology, retrieved from: http://onlinelibrary.wiley.com/doi/10.1002/(SICI)1520-6629(199809)26:5%3C429::AID-JCOP3%3E3.0.CO;2-M/abstract.

Takeuchi, D., Sue, S., & Yeh, M. (1995). Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. American Journal of Public Health, retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1615442/.

United Nations Educational, Scientific and Cultural Organization (2006) Guidebook for Planning Education in Emergencies and Reconstruction, retrieved from: http://unesdoc.unesco.org/images/0019/001902/190223e.pdf.

Woods, V.D., King, N.J., Hanna, S.M. and Murray, C. (2012) WE AIN'T CRAZY! Just Coping With a Crazy System: Pathways into the Black Population for Eliminating Mental Health Disparities. Retrieved from: http://www.cdph.ca.gov/programs/Documents/African_Am_CRDP_Pop_Rept_FINAL2012.pdf

World Health Organization (2014) Mental health: a state of well-being. Retrieved from: http://www.who.int/features/factfiles/mental_health/en/

Zukoski, A. & Luluquisen, M. (2002) Participatory Evaluation: What is it? Why do it? What are the challenges?. *Community Based Public Health Policy and Practice*, retrieved from: https://depts.washington.edu/ccph/pdf_files/Evaluation.pdf